San Francisco Culinary, Bartenders & Service Employees Trust Funds

APPLICATION FOR BENEFITS - AIDS BENEFIT FUND

RETURN THIS FORM TO:

BeneSys Administrators
1182 Market Street, Suite 320 San Francisco, CA 94102-4919
CLAIMS/BENEFITS/ELIGIBILITY: (844) 492-9157 FAX: (415) 233-9341

PART 1 - TO BE COMPLETED BY PARTICIPANT

NAME OF PARTICIPANT			SSN/PARTICIPANT ID
ADDRESS	CITY	STATE	ZIP CODE
EMAIL ADDRESS			PHONE

I REQUEST THE FOLLOWING BENEFIT(S) UNDER THE SAN FRANCISCO CULINARY, BARTENDERS & SERVICE EMPLOYEES AIDS BENEFIT TRUST FUND:

☐ RENT, MORTGAGE, OR UTILITIES ASSISTANCE **(RENT VERIFICATION FORM MUST ALSO BE COMPLETED)**

TO QUALIFY FOR THIS BENEFIT, YOU MUST BE PARTIALLY DISABLED. FOR THIS PURPOSE, "PARTIALLY DISABLED" MEANS YOU ARE UNABLE TO WORK AT LEAST 20 HOURS PER WEEK.

☐ QUALIFIED EXPENSE REIMBURSEMENT

QUALIFIED EXPENSES GENERALLY INCLUDE HEALTH AND WELLNESS RELATED EXPENSES NOT OTHERWISE COVERED BY THE PLAN. FOR A COMPLETE LIST OF QUALIFIED EXPENSES, CONTACT THE ADMINISTRATIVE OFFICE OR REFER TO YOUR PLAN BOOKLET.

IF CLAIM IS FOR RENT, MORTGAGE OR UTILITIES ASSISTANCE, YOU MUST COMPLETE THIS SECTION	NAME OF COMPANY YOU WORK FOR	
	DATE EMPLOYED	DATE OF HOURS REDUCTION DUE TO DISABILITY
	NUMBER OF HOURS SCHEDULED TO WORK WEEKLY	DATE EXPECTED TO RETURN TO FULL TIME WORK (IF APPLICABLE)

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

PARTICIPANT'S SIGNATURE	DATE SIGNED

PART 2 - TO BE COMPLETED BY ATTENDING PHYSICIAN

PATIENT NAME	
ICD-10 DIAGNOSIS AND CONCURRENT CONDITIONS	DATE PATIENT FIRST VISITED YOU FOR THIS CONDITION

IF APPLICABLE, HOW LONG WAS OR WILL PATIENT BE TOTALLY DISABLED (UNABLE TO WORK)?	IF APPLICABLE, HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED (UNABLE TO WORK AT LEAST 20 HOURS PER WEEK)?
FROM THROUGH	FROM THROUGH

PRINT NAME OF PHYSICIAN AND DEGREE			SSN OR TAX ID
STREET ADDRESS	CITY	STATE	ZIP CODE

SIGNATURE (ATTENDING PHYSICIAN)	PHONE	FAX	DATE SIGNED